

**NORTHWEST**  
**REGIONAL MENTAL HEALTH BOARD, INC.**

Central Naugatuck Valley Catchment Area Council #20  
Housatonic Mental Health Catchment Area Council #21  
Northwest Mental Health Catchment Area Council #22

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**Testimony for the Human Services Sub-committee of Appropriations  
March 4, 2011**

**by Janine Sullivan-Wiley, Executive Director,  
Northwest Regional Mental Health Board**

Good evening, Sen. Musto and Rep. Tercyak, and members of the committee.

My name is Janine Sullivan-Wiley, and I am the Executive Director of the Northwest Regional Mental Health Board, covering the 43 towns of Northwest Connecticut.

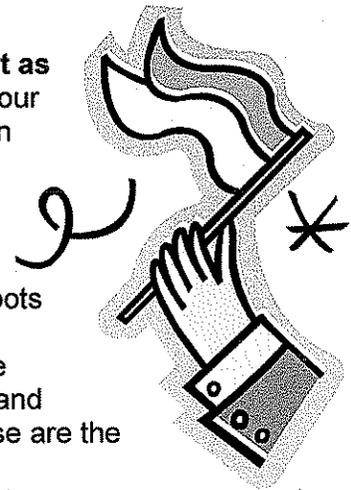
Our work, as mandated by the CT General Statutes since 1975 – and which we take very seriously – is to:

- evaluate publically funded mental health services (we evaluate over 20 programs every year)
- assess unmet needs
- and plan for and endeavor to stimulate services that are needed.

We do this with a very tiny paid staff and a very large group of volunteers— consumers, family members, general citizens and providers. During the 18 years I have been with the Board, I have had occasion to come before the legislature to make sure that you understand what we have found and what the needs are in our region.

First, I should say that **in general we are in support of the budget as proposed by Governor Malloy.** It has several components which our Board and I find essential, including preservation of the safety net in DMHAS services.

My **biggest cheer** – which I quite literally did when I heard the Governor say it – was to have **Medicaid cover smoking cessation.** I have worked for years with a small, unfunded grass-roots group called the Smoking Cessation Supports Initiative, working in regions 1 and 5. We have chronicled and been so distressed by the disproportionate impact of smoking on persons with mental illness and substance use disorders. I know the needs of this population – these are the people served by DMHAS.

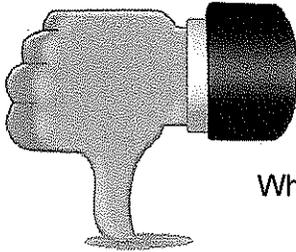


**Coverage for this** is what is needed to help people stop smoking, and will have two wonderful and major impacts:

- **It will save lives**
- **It will save Connecticut money.**

I have the data from Massachusetts on the impact of this change if you are interested.





**Unfortunately, there is another change in the proposed budget that**

- **Will not save lives**
- **Will cost the state money**

What is this two-dimensional loss?

### **Increased co-pays**

At present, there is a \$15 monthly cap on prescription co-pays. The Governor's budget proposes an increase to \$25.

This sounds like it will save money for the state, but it won't.

This amount is simply beyond the ability of many people to pay. And if they cannot afford their medication, or their mental health care, they will be forced to skip medications that help them to stay well. That means:

- Lost mental wellness.
- Which can (and often will) mean loss of a job.
- Loss of social relationships.
- Stress and upset to families and friends when they experience the deterioration of their loved one.

When that happens, the cost is now shifted to:

- Homeless shelters and services
- The jails and correctional system
- Higher levels of care within the mental health system.

In both of these situations, what is good for these individuals is good – and good fiscal sense – for Connecticut.

Thank you for your time and consideration.





## Connecticut Association of Area Agencies on Aging, Inc.

Testimony – Appropriations Committee 3/4/11

Julie Gelgauda, Care Management Director,

Agency on Aging of South Central CT, (203) 785-8533

### **Positions**

C4A supports the expansion of the Money Follows the Person (MFP) Program proposed in the Governor's budget.

C4A supports maintenance of the Connecticut Home Care Program for Elders (CHCPE) current 6% cost share of services rendered for state-funded participants and continuance of admissions for Level One Connecticut Homecare Program for Elders state-funded participants.

### **Background Statement**

Money Follows the Person Program has successfully transitioned 411 consumers to community living from institutional settings. In December a state commission reported long term spending on roughly 40,100 clients – now \$2.4 billion or 13% of the state budget- will more than double by 2025 if no action is taken. The Money Follows the Person Program is a key piece of the rebalancing effort. The Program has demonstrated success in not only assisting consumers in returning to the community, but, by providing needed supports to the consumer, the program has demonstrated the lowest rate of recidivism in the country.

In addition to rebalancing, we must maintain current community based programs to prevent institutionalization for those needing care and supports. The previously assessed co-pay of 15% caused elders in need of care to discontinue from the CHCPE as they simply could not afford the monthly co-pay. The average total plan of care is \$1,013 so an elder would be mandated to pay \$152 each month. While, at the current 6% level of cost share, some clients still opt to discontinue services, this occurs at a much lower rate and their cost share is \$61.

In 2010, the Connecticut Home Care Program for Elders (CHCPE) has an active client population of over 13,500 individuals, more than 9000 of whom received services through the Medicaid Waiver. In the CHCPE Annual Report to the Legislature for SFY 2008, the

Department of Social Services **documented cost savings to the State in that program year of \$101,931,462.** Breaking out this figure, average monthly costs per client in 2008 were as follows: Waiver clients: \$1,643; State funded clients: \$882. In 2008, this compared with an average monthly Medicaid nursing home cost of \$5,338. State support has ensured that eligible individuals can access the CHCPE on a rolling basis and that there is no wait list.

Home and community-based care is often principally described in terms of its cost efficacy. In addition to this analysis, it is also important, however, to reference its human value to older adults and individuals with disabilities. Surveys and anecdotal data show that consumers overwhelmingly prefer to receive needed services at home in the community. Through these services, an individual can 1) preserve the right to live as s/he chooses; 2) assist to the extent of ability in planning the course of his/her care; 3) retain immediate contact with loved ones; and 4) safeguard both health and dignity.

Diverse groups including the State of Connecticut Long-Term Care Planning Committee, the Nursing Home Transitions Work Group, and research institutions have emphasized the many benefits of community-based care. Ongoing efforts to shift both state policy priority and expenditure of Medicaid dollars to care at home reflect these commitments. Investing in low cost home and community-based care plans for elders in need will forestall the need for much more costly and burdensome care in nursing facilities.